## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER  REQULATORY OR LISC IDENTIFYING INFORMATION)  FREENT  TAG  REQULATORY OR LISC IDENTIFYING INFORMATION  FROM  INITIAL COMMENTS  F 000  INITIAL COMMENTS  INITIAL COMMENTS  F 000  INITIAL COMMENTS  INITIAL COMMENTS  F 000  INITIAL COMMENTS  INITIAL COMMENTS  INITIAL COMMENTS  INITIAL COMMENTS  INITIAL COMMENTS  INITIAL COMMENTS  INITIAL COMMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
RADIE OF PROVIDER OR SUPPLIER  ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER    Comparison			155426	B. WING					
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD  INITIAL COMMENTS  This visit was for the Investigation of Complaint IN00121124 and Complaint IN001221124 substantiated, no deficiencies related to the allegations are cited.  Complaint IN001221255 substantiated, no deficiencies related to the allegations are cited.  Survey dates: January 10, 11, and 14, 2013  Facility number: 000613  Provider number: 155426  AIM number: Jooye Hofmann, RN  Census bed type: SNF/NF: 167  Total: 167  Census payor type: Medicare: 35 Medicaid: 112 Other: 20 Total: 167  Sample: 3  Royal Oaks Health Care and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regards to the Investigation of Complaint IN00122455.  Quality Review completed on 01/177/2013 by Brenda Nunan, RN.					STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE				
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		Brenda Nunan, RN.				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	155426	B. WING			C 01/14/2013		
	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804					
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE	
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